

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

2008

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01984

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Water St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Lambert Last Bacchus				4. DATE OF DEATH Month Feb. Day 8. Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1894	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 7 Hours 19 Min.		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antique Dealer				10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland	
13. FATHER'S NAME Jefferson D. Bacchus				14. MOTHER'S MAIDEN NAME Lousia Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 063-05-9726		17. INFORMANT Ethel Bacchus Melamet Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer lung DUE TO Cancer of left kidney (renal cell ca of kidney with skin metastases) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 months ???	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from November 1960 to February 8, 1961 , that (I) (we) last saw the deceased alive on 2-7- 1961 , and that death occurred at 10a. M. from the causes and on the date stated above.							
22a. SIGNATURE A. C. Dick				22b. DATE SIGNED 2/9/61			
22c. PHYSICIAN'S NAME (Type) A. C. Dick				22d. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/61		23c. NAME OF CEMETERY, OR CREMATORY Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE FEB 14 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Howard							

2008

10/10/08

Enclosed, please find the report of the investigation of the alleged sexual harassment of [redacted] by [redacted] on [redacted] at [redacted]. The report is dated [redacted] and is located in the [redacted] folder of the [redacted] drive. The report is confidential and should be handled accordingly. If you have any questions, please contact [redacted] at [redacted].

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Form PM3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01985

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington (rural)	
c. LENGTH OF STAY IN TB 18 hours		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Annes			
3. NAME OF DECEASED (Type or print) GEORGE LEONARD COFFMAN		4. DATE OF DEATH Month February Day 28 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6 1942
9. AGE (in years last birthday) 18 yrs.		10. AGE (in years last birthday) Months 18 Days 18 Hours 18 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY Farm	
12. CITIZEN OF WHAT COUNTRY USA		13. BIRTHPLACE (State or foreign country) Maryland	
14. FATHER'S NAME Earl G. Coffman		15. MOTHER'S MAIDEN NAME Ethel Turner	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		17. SOCIAL SECURITY NO. 216 49 4116	
18. INFORMANT Earl Coffman, Marydel, Md.		19. ADDRESS Earl Coffman, Marydel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive electrical burns (high voltage) involving left arm and leg, lumbar area of back, and also to a lesser degree the right arm & leg DUE TO (b) 19 hours DUE TO (c) 19 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> drove a tractor into a pole and caused hi-tension wires to fall, catching under tractor and preventing his removal for about 15 minutes. Current did not stop farm near Millington, Md, Kent			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) drove a tractor into a pole and caused hi-tension wires to fall, catching under tractor and preventing his removal for about 15 minutes. Current did not stop farm near Millington, Md, Kent			
20c. TIME OF INJURY Month, Day, Year 2/27/61			
20d. PLACE OF INJURY (Home, farm, or other place) farm near Millington, Md, Kent			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farrar		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farrar		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/2/61	
22c. NAME OF CEMETERY OR CREMATORY Haldens Cemetery		22d. LOCATION (City, town, or country) Burial Sellersville Md.	
23. FUNERAL DIRECTOR Edward Yellow Millington Md.		24a. REC'D BY REGISTRAR MAR 3 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hance		DATE MAR 3 '61	

MEDICAL CERTIFICATION

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ΣΑΡΓΗ Θ. ΕΠΥΛ

On: 15 Aug

Robert L. Jones

217

217

222

Robert M. Fortin

CERTIFICATE OF DEATH

Reg. Dist. No.

2010

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kennedyville c. LENGTH OF STAY IN TB Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kennedyville d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary E. Comegys		4. DATE OF DEATH Month Day Year Feb. 22 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20 1882
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY farm home	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas George		14. MOTHER'S MAIDEN NAME Amanda Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs. Chas. Olin Powell		Address Kennedyville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholera 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholera DUE TO (c) Cholera		INTERVAL BETWEEN ONSET AND DEATH 2 DAY 1 Wk 1 Wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Palpable nodule on liver - possible metastatic ca			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/22/ 1961 to 2/23 1961 , that I last saw the deceased alive on 2/22 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chrstertown, Md. DATE SIGNED 2/25/61			
ACTUAL SIGNATURE Thomas J. Solon		M.D. 2/25/61	
PHYSICIAN'S NAME (Type) Thomas J. Solon		Chrstertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/25/61	22c. NAME OF CEMETERY OR CREMATORY Kennedyville Cemetery	22d. LOCATION (City, town, or county) (State) Kennedyville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		24a. REC'D BY REGISTRAR FEB 27 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the funeral director or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1944

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY

WASHINGTON, D.C.

January 10, 1944

Dear Sir:

I am pleased to hear from you.

Very truly yours,

W. L. RORER

Assistant Secretary

U.S. Department of Agriculture

Washington, D.C.

Enclosed for you are

three copies of the

report of the

committee on

the subject of

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Kennedyville		c. LENGTH OF STAY IN 1b Short	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Railroad Eng. Accident (Penna. RR)		d. STREET ADDRESS 606 Jewell St	
3. NAME OF DECEASED (Type or print) Joseph Carlas Dickerson		4. DATE OF DEATH Feb. 5, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/1910
9. AGE (in years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Penna. R. R. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Delaware	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Dickerson		14. MOTHER'S MAIDEN NAME Amanda Givens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 717-12-5143	
17. INFORMANT Geraldine Dickerson, Delmar, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injuries to chest & abdomen 800 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was crushed as result of RR. derailment	
20c. TIME OF INJURY Month, Day, Year 8:30 2/5/61 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad		20f. (City or town) (County) (State) near Kennedyville Kent Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Gammal Co - Delmar, Del		24a. REC'D BY REGISTRAR FEB 8 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur E. Hance	

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2012

CERTIFICATE OF DEATH

01988

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bettertown		c. LENGTH OF STAY IN 1b 21 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bettertown		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Henry Middle Fleckenschildt Last 		4. DATE OF DEATH Month Feb. Day 16, Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale Meats		10b. KIND OF BUSINESS OR INDUSTRY retired	
11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Fleckenschildt		14. MOTHER'S MAIDEN NAME Margaret Boggs.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-18-8700	
17. INFORMANT Mrs. Edgar Harris		Address Chestertown, Md. daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old coronary artery disease DUE TO 10 years (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 minute 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1955 to 19 , that (I) never last saw the deceased alive on Nov 8 19 61 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Florence D. Joyce		22b. ADDRESS RFD Worton Maryland	
22c. PHYSICIAN'S NAME (Type) Florence D. Joyce		22d. ADDRESS RFD Worton Maryland	
22e. DATE 2/17/61		22f. SIGNED Arthur S. Knaus	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 20, 1961	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DATE FEB 23 '61	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

STANDARD FORM NO. 64

1-10-55

(1)

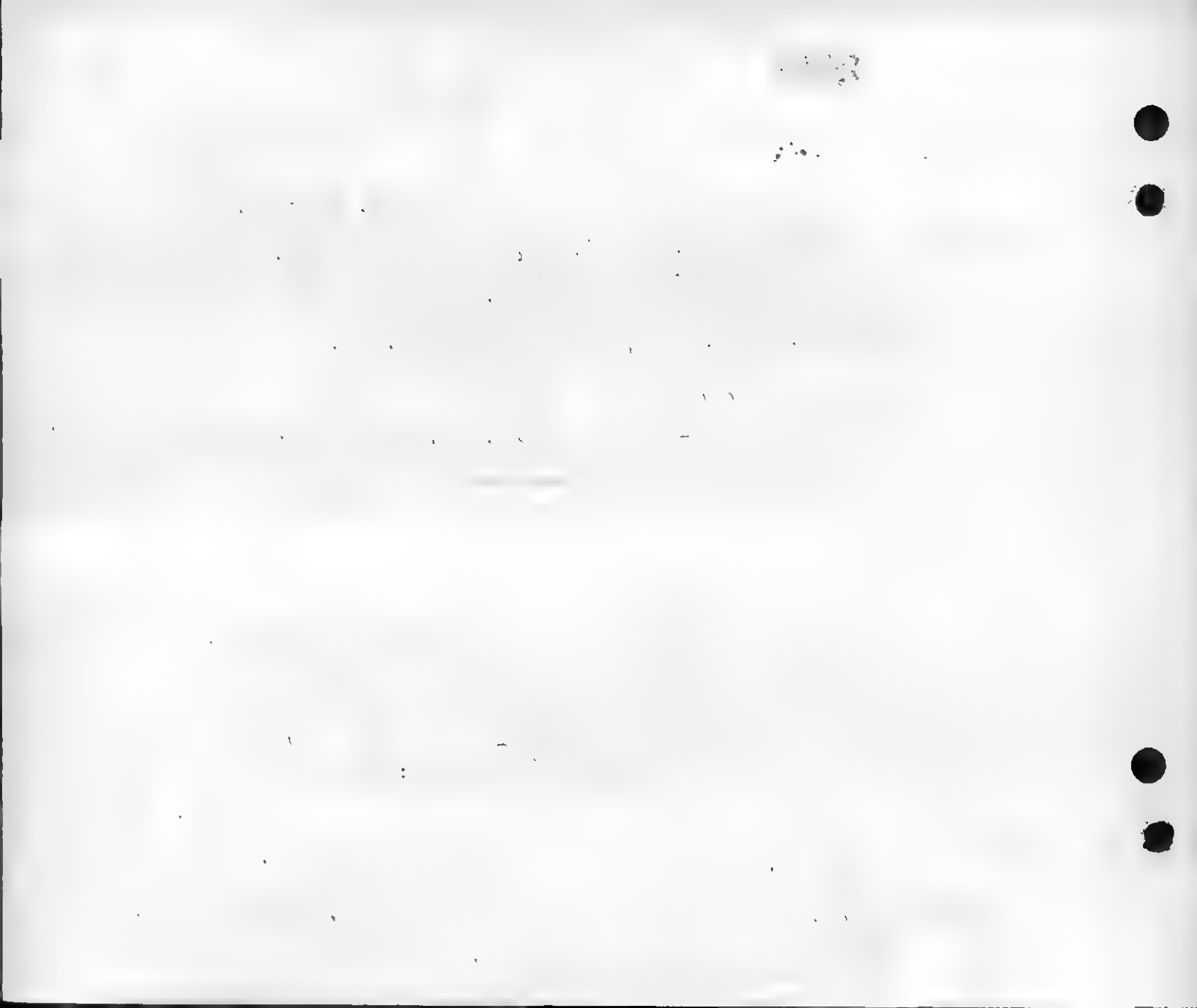
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

0198.1

2013

1 PLACE OF DEATH a. COUNTY <i>Kent</i> <i>Lifetime</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lynch</i>		c. LENGTH OF STAY IN 1b <i>9 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>At Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>William Webster Hadaway</i>		4. DATE OF DEATH Month Day Year <i>Feb. 27, 1961</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Dec. 14, 1890</i>
9. AGE (In years last birthday) <i>70</i>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Automobile Mechanic (laborer)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Kent Co. Md.</i>	
11 BIRTHPLACE (State or foreign country) <i>Kent Co. Md.</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Daniel Hadaway</i>		14. MOTHER'S MAIDEN NAME <i>Alice Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>216-01-6062</i>	
17. INFORMANT <i>Mrs. Wm. Webster Hadaway</i>		Address <i>Lynch, Md.</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intracranial hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs 40 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/27</i> <i>1961</i> to <i>2/27</i> <i>1961</i> , that (I) (we) last saw the deceased alive on <i>2/27</i> <i>1961</i> and that death occurred at <i>3:40 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Farr</i>		22b. DATE <i>Feb. 28, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Farr</i>		22d. ADDRESS <i>Chestertown, Md.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar. 2, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Chester Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Chestertown, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		25a. REC'D BY REGISTRAR <i>Feb 2 '61</i>	
ADDRESS <i>Chestertown, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician or attending physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2014

01990

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b one-half hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Phillips Last Phillips		4. DATE OF DEATH Month 2 Day 1 Year 19 61					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months Days Hours Min	F UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-142801		17. INFORMANT WM. LEARY Address Rock Hall Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Over Exposure to Weather 732.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/61 to 2/1/61 19____, that (I) (we) last saw the deceased alive on 2/1/61 19____, and that death occurred at 1 M, from the causes and on the date stated above.							
22a. SIGNATURE Wm. W. Gatewood				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) WILLIAM GATEWOOD	
22d. ADDRESS Rock Hall, Md.				22e. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		2/4/61		Wesley Chapel		Rock Hall Md	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L Lane				25a. REC'D BY REGISTRAR DATE FEB 7 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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FOR STATE
HEALTH DEPT.

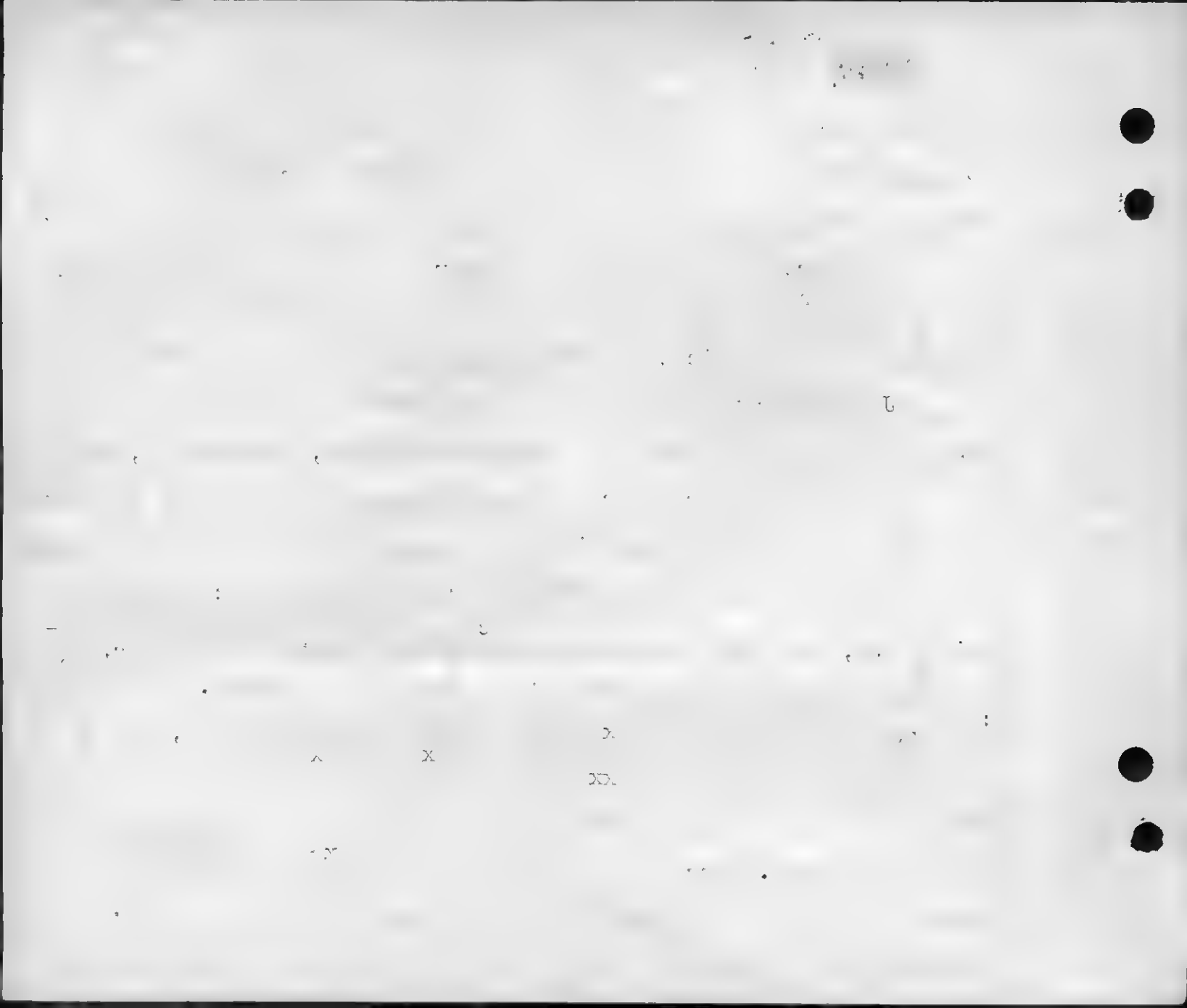
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary for the funeral director, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01991

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sudlersville (rural)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Annes		d. STREET ADDRESS Sudlersville (rural)	
3. NAME OF DECEASED (Type or print) Earl Spencer		4. DATE OF DEATH Month 2 Day 20 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/31
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME John Spencer		14. MOTHER'S MAIDEN NAME Martha Beale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 219-34-6625	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central nervous system damage DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Carbon monoxide poisoning DUE TO (c) Was found in his one-room home about 9:30 AM 2/20/61 & was brot to hospital in an Un conscio s state. Never regained conscio sness, and died in terminal hyperpyrexia about 30 hrs later. A coal heater was discharging gass into the room.		17. INFORMANT Hospital Records, Chestertown, Md.	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/>		20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20c. TIME OF INJURY Month, Day, Year 2/20/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery	
22b. LOCATION (City, town, or country) Sudlersville Md.		22c. DATE THEREOF Feb. 23, 1961	
23. ACTUAL SIGNATURE Robert W. Farr		24. DATE SIGNED 2/21/61	
23. EXAMINER'S NAME (Type) Robert W. Farr		24. DEPUTY MEDICAL EXAMINER Edward Fellows	
25. BURIAL, CREMATION, REMOVAL (Specify) Burial		26. REC'D BY REGISTRAR FEB 24 '61	
25. DATE THEREOF Feb. 23, 1961		26. REGISTRAR'S SIGNATURE Charles S. Kraus	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2016

CERTIFICATE OF DEATH

Reg. Dist. No. 01992

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. 1 Chestertown		c. LENGTH OF STAY IN 1b 44 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lydia Virginia Whittington		4. DATE OF DEATH February 11 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1895
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Ruth Whittington, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO (b) Arteriosclerosis, Hypertension Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Arteriosclerosis Generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Concurrent Heart Failure / 2 Previous Strokes 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/30 , 19 58 , to 1/31/61 , 19 61 , that I last saw the deceased alive on 1/31/61 , 19 61 , and that death occurred at 12:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown Md. 2/11/61 DATE SIGNED			
ACTUAL SIGNATURE Thomas J. Solon		M.D. Chestertown Md. 2/11/61	
PHYSICIAN'S NAME (Type) Thomas J. Solon		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/68	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.	
24a. REC'D BY REGISTRAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur E. Krawe	

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STATE OF NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2017

CERTIFICATE OF DEATH

Reg. Dist. No. 01993

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 4 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Duyer Apts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle Wilkins Last		4. DATE OF DEATH Month Feb. Day 27 Year 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29 1873
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Chestertown Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Mifflin Wilkins		14. MOTHER'S MAIDEN NAME Mary Anna Merritt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
INFORMANT Miss Grace Wilkins		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral insufficiency DUE TO (c) Old rheumatic heart disease ??		INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1 , 19 60 , to 2-27 , 19 61 , that I last saw the deceased alive on 2-26 , 19 61 , and that death occurred at 3:40 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 2-27-61			
ACTUAL SIGNATURE A. C. Dick		M.D.	
PHYSICIAN'S NAME (Type) A. C. Dick		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 1/ 61	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR MAR 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

